

FURLOUGH REFERRAL AND APPLICATION FORM

TYPE OF FURLOUGH REQUESTED (circle one)

Family Emergency Short-Term Ch. C. Art. 897.1 Standard**REFERRAL BY STAFFING COMMITTEE**

(to be completed at staffing)

Youth: _____ DOB: _____ Client ID # _____

Date of Direct Admission: _____ Facility: _____ Dorm: _____

Date of Transfer to Current Facility: _____

Full-Term Date: _____ Committing Court: _____

Judge(s): _____

Estimated Program Completion Date: _____

Committing Offense(s): _____

Amount of Time at Facility: _____ % of Sentence Served: _____ (897.1 only)

Crime Victim Notification (La. Ch. C. Art. 897.1) ☐ Yes ☐ No

Pending Charges: _____

Detainers: _____

Prior(s) Resulting in Placement/Commitment: _____

Escape History: _____

CUSTODY CLASSIFICATION LEVEL HISTORY:

Current Custody Level: _____ Classification Date: _____

Previous Custody Level: _____ Classification Date: _____

DISCIPLINARY INFRACTION REVIEW: (Attach disciplinary printout for previous 12 months where appropriate.)

Number within most recent 30 days: MAJOR: _____ MINOR: _____

Most serious (or pending) infraction: _____

Restrictions / Consequences imposed: _____

Number within previous 30 days: MAJOR: _____ MINOR: _____

Most serious (or pending) infraction: _____

Restrictions / Consequences imposed: _____

Within past 6 months: MAJOR: _____ MINOR: _____

Most serious (or pending) infraction: _____

Restrictions / Consequences imposed: _____

Recommended length of furlough: _____

UNIT MANAGEMENT TEAM REVIEW

(to be completed by Unit Management Team)

Referral received by (member of Unit Management Team): _____ Date: _____

If youth is currently identified as having a serious mental illness (SMI), are there any concerns that would impact furlough participation? _____
_____Are there concerns regarding psychotropic medication(s)? _____

_____If youth currently has a medical condition, are there any concerns that would impact furlough participation? _____
_____Are there concerns regarding any medications? _____

PROGRAM PARTICIPATION (Provide program information relative only to needs identified in treatment plan):

| | <u>Name of Program</u> | <u>Facilitator's Name</u> | <u>Progress</u> |
|----|------------------------|---------------------------|-----------------|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |

Comments: _____

Attach the most recent quarterly/monthly progress reports.

Educational and Vocational Performance/Needs: _____
_____Furlough Consistent with Aftercare / Release Plan: _____

_____**HOME ENVIRONMENT and SUPPORT**☐ Yes ☐ No Is the environment suitable for the youth to have the support and supervision needed for a furlough?☐ Yes ☐ No Has the youth received any mail, packages, telephone calls or other correspondence from his/her parent/responsible family member within the past 30 days?☐ Yes ☐ No Does CBS indicate that the home and home environment are suitable for the youth to return to for a placement upon release from secure custody?☐ Yes ☐ No If so, does CBS object to the youth being checked out by the legal guardian for an off-campus restricted visit to the facility domicile area?

C.4.1 (a)

☐ Yes ☐ No Has the parent/responsible family member participated in three Family Reintegration Sessions with the last most recent being in the last 30 days at the facility?

☐ Yes ☐ No Has the youth received a visit from the parent/responsible family member within the past 90 days? (please note type and dates below)

_____ Regular Visitation: _____

_____ Family Therapy Visit: _____

_____ On or Off Campus Visit: _____

_____ Special Visit: _____

Can approved parent/responsible family member provide transportation to and from facility? ☐ Yes ☐ No If yes, who? _____

If no, what arrangements will be made for transportation of the youth? _____

Will youth be required to wear an Electronic Tracking Device while on furlough?

☐ Yes ☐ No

If yes, what is the name, phone number and office address of the individual who will be tracking the youth? _____

Curfew from: _____ to: _____

(If blank, curfew begins at 6:00 p.m. and ends to 7:00 a.m.)

Furlough to begin on: _____ end on: _____
Date Time Date Time

Activities to be completed while on furlough:

1. _____

2. _____

3. _____

4. _____

5. _____

Appointments to be kept while on furlough:

1. _____ With Whom: _____

2. _____ With Whom: _____

3. _____ With Whom: _____

MEMBERS OF UNIT MANAGEMENT TEAM:

| | | |
|---------------|----------------|---------------|
| _____ Name | _____ Title | _____ Date |
| _____ Name | _____ Title | _____ Date |
| _____ Name | _____ Title | _____ Date |
| _____ Name | _____ Title | _____ Date |

| |
|---|
| <i>Is FURLOUGH recommended?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|

Group Leader's Signature_____
Date

| |
|---|
| <i>FURLOUGH:</i> <input type="checkbox"/> Approved <input type="checkbox"/> Denied |
|---|

Director's Signature
(Deputy/Assistant Director if Director is absent)_____
Date

| |
|---|
| <i>FURLOUGH:</i> <input type="checkbox"/> Approved <input type="checkbox"/> Denied |
|---|

Deputy Secretary OJJ_____
Date

| |
|---|
| <i>FURLOUGH:</i> <input type="checkbox"/> Approved <input type="checkbox"/> Denied |
|---|